Editorial

Centers of excellence for penile prosthetics are a novel concept that will likely prove difficult to implement

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The surgical implantation of penile prosthetics has been evolving over many decades. The operation offers a durable treatment solution associated with a low complication rate and high patient satisfaction. The surgery itself is traditionally taught during urological residency; however, variable patient demographics and faculty expertise leads to differences amongst trainees nationwide. Only 15% of urology training programs have a dedicated prosthetic urologist. Indeed, overall perception of the penile prosthesis amongst general urologists is fraught with misinformation about high complication rates and poor outcomes (1). One strategy to overcome a lack of prosthetics exposure in residency is to have a traveling expert perform one or two operative training sessions (of 3–4 implants) per year (2). Other options include mini-fellowships and weekend courses. The prosthetics manufacturers traditionally sponsor these programs and studies on their effectiveness are limited. In 2015, the majority of penile prostheses (>75%) were placed by urologists who performed fewer than 5 implant surgeries per year (3). Thus, while penile prosthesis surgery is easily considered a low volume surgery for most; it is made exponentially more difficult by the lack of training received.

Some have proposed to develop a concept mimicking that seen in other surgical specialties such as orthopedics where hip replacements (4), for example, are preferentially performed at "Centers of Excellence" (CoE). These high-volume locations have been proven to improve patient outcomes—but the concept has yet to gain traction in the field of penile prosthetics. Henry and colleagues (5) published a small study that identified shorter operating times, improved mean cylinder length implanted and fewer iatrogenic complications in surgeries performed by one high volume implanter when compared to multiple, lower volume surgeons. While the data in this study were too small and had too many flaws to draw any meaningful conclusions (6), the basic philosophy was titillating—could a CoE be created for penile prosthetics? While further studies would obviously need to be conducted in order to see if any benefits are elucidated, some simple questions cast some doubt upon the likelihood that such a model could even be established.

The first question that would need to be answered is likely the simplest: How is a CoE defined? Would a strict cut-off of greater than 25 penile prostheses implanted per year be a selection criterion? How would anyone be able to define the number of implants conducted? Would infections, longer operating times and patient outcomes influence any proposed CoE designation? While most experts would consider a volume of 25 implants per year to represent a high surgical volume (5), the exact number is unknown. Given that manufacturers (AMS/Boston Scientific and Coloplast) are hesitant to release *any* specific surgeon data regarding surgical volume, it is unlikely that independent accuracy could ever be recorded.

Lastly, how many prosthetic urologists would be needed to comprise a CoE? As stated above, there are a small amount of urologists that perform penile implants. This is radically different from total hip replacements where the volume is so high that 4–5 surgeons contribute to a significant portion of the operations conducted. As such, is a CoE really just one surgeon who does a lot of cases? As

evidenced, while it is tempting to speculate that the CoE concept would be advantageous; much work needs to be done in order to tease out the most optimal scenarios.

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Footnote

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